Prior Authorization

When the quantity of the prescribed DMS will exceed the limit, providers should receive PA approval *before* dispensing any quantity, including the quantity available without PA.

In specific circumstances, prior authorization (PA) is required to dispense disposable medical supplies (DMS). Refer to the Prior Authorization section of the All-Provider Handbook for detailed information on seeking PA as it applies to all providers.

Providers should obtain PA, when required, *before* providing a service. Payment is not made for services provided either before the grant date or after the expiration date on the approved Prior Authorization Request Form (PA/RF). If the provider delivers a service that requires PA without first obtaining PA, the *provider* is responsible for the cost of the service.

Prior authorization does not guarantee reimbursement from Wisconsin Medicaid. Provider eligibility, recipient eligibility, and medical status on the date of service, as well as all other Medicaid requirements, must be met before the claim is reimbursed.

When to Request Prior Authorization

Prior authorization is required for the following items:

- All DMS items that are not used for their intended purpose, such as a foley catheter used for a feeding tube.
- All DMS that exceed the maximum quantity limits listed in the DMS Index.
- All DMS that require PA, as indicated in the DMS Index.
- Exceptional supplies for nursing home recipients who meet the exceptional supplies criteria. (Refer to Appendix 3 of this handbook for more information on exceptional supplies.)
- Prescribed DMS that are not included in the DMS Index, but meet the medical necessity criteria for Medicaid coverage. This includes the use of the "not otherwise classified" procedure code and similar procedure codes.

Providers requesting PA for DMS should submit a PA/RF and a Prior Authorization Durable Medical Equipment Attachment (PA/DMEA) to Wisconsin Medicaid.

Disposable Medical Supplies That Exceed Quantity Limits

Nearly all DMS listed in the DMS Index are available in the quantity stated without PA. (The DMS Index indicates which items require PA.) When a recipient whose medical needs for additional quantities exceed those limits, PA is required.

When the quantity of the prescribed DMS will exceed the limit, providers should receive PA approval *before* dispensing any quantity, including the quantity available without PA.

For example, if a recipient's prescription is for 150 insulin syringes per calendar month (procedure code W1327) and the DMS Index specifies that 100 syringes are available per calendar month without PA, the provider is required to request PA for the entire 150 syringes. Indicate in Element 19 of the PA/RF that 150 syringes are needed per calendar month. In this example, the provider should receive PA approval before dispensing any of the 150 syringes.

Prior authorization requests for *additional* DMS must include the following:

- A copy of the prescription dated within six months of receipt by Wisconsin Medicaid.
- Documentation of current medical necessity, individualized for each recipient. (Documentation should be of sufficient detail and content related to the requested item and additional quantity.)

- The desired grant date, which is the first date the PA is effective and the earliest date that *any* of the DMS may be dispensed.
- The expected duration of need.
- The *total* quantity needed per calendar month. (The maximum quantity allowed in the DMS Index plus the additional quantity needed.)

Exceptional Supplies for Nursing Home Recipients

Refer to Appendix 3 of this handbook for more information on PA procedures for exceptional supplies for nursing home recipients.

Disposable Medical Supplies Not Listed in the Disposable Medical Supplies Index

Under some circumstances, a provider may need to dispense an item that is not listed in the DMS Index (i.e., the DMS Index does not list a procedure code for that item). Wisconsin Medicaid may prior authorize the dispensing of this item if the item meets the medical necessity criteria for coverage.

When submitting a PA/RF for supplies that are not listed in the DMS Index, providers should either:

- Use the procedure code of the item that most closely matches the DMS that the provider wants to dispense.
- Use the "not otherwise classified" procedure code (W6499) when the DMS Index does not list a similar procedure code for the DMS that the provider wants to dispense.

On the PA/RF, indicate:

- The procedure code in Element 14.
- The modifier "PA" in Element 15.

Prior authorization requests for a DMS item that is not listed in the index must include the following:

- A complete description of the item.
- Product information for the item.
- Documentation of medical necessity.
- The specific brand name and item number of the item.
- A copy of the manufacturer's invoice.
- The quantity requested and the duration of use.
- A copy of the prescription dated within six months of receipt by Wisconsin Medicaid.

Prior Authorization and Coordination of Benefits

When DMS require Wisconsin Medicaid PA, and the recipient has commercial health insurance or Medicare coverage, the provider is encouraged, but not required, to obtain PA from Wisconsin Medicaid. This offers the provider the opportunity to receive reimbursement from Wisconsin Medicaid in the event that the commercial health insurance or Medicare does not provide reimbursement.

If the service is provided before PA is obtained, Wisconsin Medicaid will not backdate a PA request simply to enable the provider to receive reimbursement.

For managed care enrollees, providers should contact the enrollee's managed care program for specific information on its PA policies and procedures.

Modifiers

When requesting PA for an item, providers are required to include the appropriate modifier for that item if the modifier is listed in the DMS Index. This is true even if the DMS Index indicates the modifier is not required for billing purposes.

When requesting PA for an item, providers are required to include the appropriate modifier for that item if the modifier is listed in the DMS Index.

Prior Authorization Forms

Providers who dispense DMS are required to use Wisconsin Medicaid's PA/RF and the PA/DMEA when seeking PA.

Wisconsin Medicaid makes all decisions on PA requests within the time frames outlined in the Prior Authorization section of the All-Provider Handbook, regardless of whether the requests are mailed or faxed.

Each PA/RF has a unique seven-digit, pre-printed number in the upper center of the form. This number is the PA number that must be used on a claim because it identifies the service on the claim as a service that has been prior authorized.

Wisconsin Medicaid requires providers to submit each *new* request for PA on a *new* PA/RF so that the request is processed under a *new* number. Since the PA/RF number is used to identify a single PA request, do not photocopy this form for other requests.

Refer to Appendix 5 of this handbook for PA/RF completion instructions. Completed samples of PA/RFs are included in Appendices 6, 7, 8, and 9 of this handbook.

Refer to Appendix 10 of this handbook for PA/DMEA completion instructions. A completed sample PA/DMEA form is included in Appendix 11. The PA/DMEA sample is linked with the PA/RF sample in Appendix 6. A blank PA/DMEA is included in Appendix 12.

Providers may print copies of the PA/DMEA included in Appendix 12 of this handbook. Providers may also obtain copies of the PA/RF and PA/DMEA by calling Provider Services at (800) 947-9627 or (608) 221-9883, or by writing to:

Wisconsin Medicaid
Form Reorder
6406 Bridge Rd
Madison WI 53784-0003

Submission of Prior Authorization Forms

Providers have two choices for submitting completed PA requests:

- By fax.
- By mail.

Prior authorization requests received after 1 p.m. are processed on the following business day. Prior authorization requests received on Saturday, Sunday, or legal holidays are processed on the next business day.

Wisconsin Medicaid makes all decisions on PA requests within the time frames outlined in the Prior Authorization section of the All-Provider Handbook, regardless of whether the requests are faxed or mailed.

Note: Providers may only submit PA requests containing X-rays or photos by mail.

Submission by Fax

Providers may fax PA requests to Wisconsin Medicaid at (608) 221-8616.

When faxing PA requests, providers are required to submit all forms and documentation together; they should not fax the forms and then mail the supporting documentation separately. Providers should not submit PA requests by mail if they have already faxed their PA requests.

In addition, refaxing a PA request before the previous request has been returned will create duplicate PA requests and may result in delays.

It is not necessary to reduce the size of the PA request form to fit on the bottom half of the cover page. This makes the PA request difficult to read and leaves no space for consultants to write a response if needed or to sign requests.

To help safeguard the confidentiality of patient health care records, providers should include a fax transmittal form containing a confidentiality statement as a cover sheet to all faxed PA requests. Providers are reminded to include their fax number on the transmittal form.

Response Back From Wisconsin Medicaid

Once Wisconsin Medicaid reviews a PA request, Wisconsin Medicaid will fax one of three responses back to the provider:

- "Your request(s) has been adjudicated. See attached PA request(s) for the final decision."
- "Your request(s) requires additional information. See attached PA request(s). Fax the requested information with the same PA form immediately to expedite the finalization of your request."
- "We are unable to read your faxed PA request. Please resubmit the same request."

When additional information is requested, providers are required to resubmit the faxed copy of the entire original PA request, including attachments, with the additional information requested. If any attachments or additional information are received without the rest of the PA request, the information will be returned to the provider.

Providers are required to resubmit the faxed copy because it includes Wisconsin Medicaid's 15-digit internal control number on the top-half of the form. This allows the provider to obtain the earliest possible grant date for the PA request (apart from backdating for retroactive eligibility).

Wisconsin Medicaid will mail the decision back to the provider if:

- The provider does not include his or her fax number on the transmittal form.
- The fax is not successfully transmitted after three attempts.

Submission by Mail

Providers may mail completed PA/RFs and PA/DMEAs to:

Wisconsin Medicaid
Prior Authorization
Ste 88
6406 Bridge Rd
Madison WI 53784-0088

For reference or further correspondence, providers are encouraged to photocopy their paperwork before sending it in.

Review of Prior Authorization Decisions

After review by Wisconsin Medicaid consultants, the PA request is:

- Approved.
- Approved with modification.
- Denied.
- Returned to the provider for additional clinical information or clarification.

Refer to the Prior Authorization section of the All-Provider Handbook for more information on each of these responses.

Only recipients can appeal modified or denied PA requests. When a request is modified or denied, the recipient receives a "Notice of Appeal Rights" letter. Refer to the Prior Authorization section of the All-Provider Handbook for a copy of this letter and for information on how a provider and a recipient may respond to Wisconsin Medicaid's review of a PA request.

When additional information is requested, providers are required to resubmit the faxed copy of the entire original PA request, including attachments, with the additional information requested.

Amending Prior Authorization Requests

If a recipient's need for DMS changes during the time period approved on the PA/RF, the provider can request that the approved PA be amended. Providers should send a letter to Wisconsin Medicaid Prior Authorization and attach:

- A copy of the currently approved PA/RF.
- A copy of the physician's, physician assistant's, or nurse practitioner's order for additional DMS.
- Documentation of the medical necessity for additional DMS.
- The anticipated length of time the additional DMS will be needed.

Amended requests can be faxed to (608) 221-8616 or mailed to:

Wisconsin Medicaid
Prior Authorization
Ste 88
6406 Bridge Rd
Madison WI 53784-0088